# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

**Type of Requestor:** (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

| | |
|---|---|
| Requestor's Name and Address<br>Surgical & Diagnostic Center<br>729 Bedford Euless Road West, Ste. 100<br>Hurst, TX 76053 | MDR Tracking No.: M4-03-8349-01<br>TWCC No.:<br>Injured Employee's Name: |
| Respondent's Name and Address<br>Old Republic Insurance Co.<br>c/o ECAS<br>Box 02 | Date of Injury:<br>Employer's Name: Wickes Furniture Co., Inc.<br>Insurance Carrier's No.: YBUC 20810 |

## PART II: SUMMARY OF DISPUTE AND FINDINGS

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| 07/30/02 | 07/30/02 | 62290 - Discography | $1,556.50 | $0.00 |
| 07/30/02 | 07/30/02 | 72110 – X-Ray | $50.00 | $0.00 |
| | | | | $0.00 |

## PART III: REQUESTOR'S POSITION SUMMARY

Surgical and Diagnostic Center contends that the fee paid was not fair and reasonable because it is below the amount the majority of the other insurance carriers are reimbursing and does not take into account all of the supplies and medications to treat this patient, the amount of time spent in the operating room and other costs. The fee paid does not ensure effective medical cost control because it does not properly compensate for items specifically needed by and provided to the patient.

## PART IV: RESPONDENT'S POSITION SUMMARY

The Acute Care Fee Guidelines were used as a consideration in determining reimbursement. However, this does not mean that inpatient guidelines were applied to this service.

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (from 173.9% to 226.5% of Medicare for this particular year). Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. Based on this review, the original reimbursement on these services is within the high end of the Ingenix range. According to CMS ASC guidelines, CPT Code 72110 – x-ray, is included in the facility fees. The decision for no additional reimbursement was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the decision and discussed the facts of the individual case.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that no additional reimbursement is due for these services.

**PART VI: COMMISSION DECISION**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

**Findings and Decision by:**

| | Marguerite Foster | August 9, 2005 |
|---|---|---|
| Authorized Signature | Typed Name | Date of Decision |

**PART VII: YOUR RIGHT TO REQUEST A HEARING**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____